APPLEGATE VALLEY FAMILY MEDICINE
NEW PATIENT MEDICAL REVIEW

NAME_____ AGE _____ DATE OF BIRTH _____

What is the main reason you have made this appointment? _____

Marital status (circle one) single married separate divorce widowed partnered child

Name of spouse/partner/parent _____ Spouse/partner's occupation _____

Who is at home with you? _____

Any significant changes in household (divorce, childbirth, etc.)? _____

What is/was your work? _____

Last grade of schooling completed: _____

What recreational interests do you have? _____

(If needed, please attach an additional page to complete the following questions)

MEDICATIONS

List your medications and the dose you take

Name	Pill strength	How often taken	When first begun
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DRUG ALLERGIES: Which medications can't you take? Reaction:

_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY

If you have had any of these medical problems, please circle them and write in the date you were first told you had that problem.

Diabetes	Heart attack	Hepatitis	Cancer (type)
High blood pressure	Angina (chest pains)	AIDS	COPD/emphysema
Rheumatic fever	High cholesterol	Asthma	Ulcers
Heart murmur	Stroke	Arthritis	Hiatal hernia/reflux

Other medical problems. Please list:_____

Operations: List and give approximate dates._____

Smoking – current use (packs per day) _____

Past use (or how many years have you smoked?)_____

What was your average pack(s) per day for this time? _____

Special diet _____
Birth weight (children) _____
Circle: smoking or nonsmoking household
Gestational age (premature/not premature)

Alcohol – current use _____ Average use in the past _____

Recreational drugs – current use_____ Past use:_____ Current weight _____ Maximum weight _____ Weight changes over past year_____

FAMILY MEDICAL HISTORY:	if living		if deceased	
	age	health	age at death	cause of death
Father:				
Mother:				
Brothers or sisters:				

Number of children (or siblings) and their ages:_____

Health problems of children? _____

Has any blood relative had any of the following problems? (**circle**)

diabetes high blood pressure heart attack colon cancer breast cancer other cancer
sudden death other heart disease mental illness

Please CIRCLE any of the conditions you have had OR currently have as a chronic problem:

GENERAL:
- unusual fatigue or weakness
- chills, fever
- bleeding tendency

EYES:
- vision loss
- blind areas
- seeing double

EARS:
- hearing loss
- ear infections
- vertigo/dizziness

THROAT AND MOUTH:
- sore mouth, tongue, lips
- hoarseness

HEART:
- irregular or skipped beats
- racing or fluttering
- pounding heart
- phlebitis
- chest pain
- swollen feet, ankles, hands
- murmur

NERVOUS SYSTEM:
- dizziness
- blackout spells
- little strokes (TIA's)
- numbness or tingling
- paralysis
- seizures

BONES, JOINTS, MUSCLES:
- painful or stiff joints
- back pain
- cramps in muscles of legs
- varicose veins

SKIN:
- skin cancer
- itching
- hair loss
- rash

BREAST:
- lump or discharge

LUNGS:
- persistent cough
- coughing up blood, pus, mucus
- shortness of breath
- wheeze
- sit up to breathe

STOMACH AND INTESTINES:
- difficulty swallowing
- jaundice (yellow skin)
- frequent indigestion or heartburn
- pancreatitis
- nausea/vomiting
- gallbladder disease
- diarrhea/constipation
- black stools
- abdominal pain/stomachache

GENITO-URINARY:
- pain or burning on urination
- kidney stones
- night frequency (excessive)
- impotence
- slow starting or stopping
- loss of libido (sex drive)
- discharge, bloody or dark urine
- syphilis, gonorrhea or Chlamydia

MOODS/PSYCHIATRIC:
- lack of memory
- alcoholism
- depression
- drug dependence, addiction
- anxiety
- nervous breakdown
- extreme mood swings/bipolar disorder
- other mental condition

MENSTRUAL/GYNECOLOGICAL:
- bleeding after intercourse
- abnormal vaginal bleeding — date of last period:_____
- abnormal Pap smear — date of last PAP:_____
- hot flashes/night sweats — date of last Mammo:

ABUSE: (Are you unsafe in any way?)
- physical
- verbal
- emotional
- sexual

SIGNATURE_____ DATE COMPLETED _____